Over this area the breath sounds were nearly absent, while above moist rales were heard. On the affected side the diaphragm moved only slightly. McKechnie believed the patient had a liver abscess with perforation of the diaphragm and pleura; and was intermittently evacuating the cavities through the bronchi. McKechnie's treatment was as follows: The patient was placed over the edge of a table, head downwards, with the whole body hanging upside down. The legs and thighs on the table, lay at right angles to the trunk and thus supported it. In this position the patient coughed and squeezed until no more pus came out. The maneuver was repeated five or six times daily. In this way at first, the patient got rid of large quantities of pus which rapidly diminished and in six weeks stopped. The general condition improved markedly. McKechnie suggests that this method should be tried in abscess of the lung and bronchiectasis before resorting to the more formidable surgical procedures.

The Blood Picture in Disease of the Glands of Internal Secretion.—L. Borchardt (*Deutsch. Arch. f. klin. Med.*, 1912, cvi, 182) has extended the study of the blood in disease of the glands of internal secretion. Within the last few years diseases of the thyroid gland have been studied in particular. The present observations are of interest in connection with the findings in thyroid disease, because of the similarity of the blood pictures. Borchardt finds that not only in Basedow's disease, but also in all other diseases of the thyroid, hypophysis, and adrenals the blood is characterized in the majority of cases by a relative and absolute increase of the mononuclear cells, particularly the lymphocytes. In about half of the cases there is also a leukopenia and eosinophilia is about equally frequent. Similar changes are found in the blood of patients with the clinical signs of status thymolymphaticus. Since clinical and anatomical evidence of status thymo-lymphaticus is at hand in many instances of disease of the thyroid, hypophysis, and adrenals, it is possible that the blood picture in such cases is attributable to the status lymphaticus.

A Source of Error in Nylander's Test for Glucose.—E. Strauss (*Münch. med. Woch.*, 1912, lix, 85) found a negative Nylander's test for sugar in the urine of a diabetic, whose urine was shown to contain an abundance of sugar by the Fehling and polariscopic methods. It was found that the patient was receiving inunctions of iothion (d-iiodoxypropan). On adding this substance to diabetic urine or to solutions of sugar, the Nylander reaction became negative, though there was no interference with the reduction of copper. The addition of potassium iodide or iodine is without effect. It appears that the iothion is excreted in the urine as such and forms some combination with the bismuth which prevents its reduction. ·

Diastase in Urine and Feces.—A. Lindemann (*Zeitschr. f. klin. Med.*, 1912, lxxv, 58) has studied the excretion of diastase in urine and feces, particularly in pancreatic disease. With normal gastric secretion the normal diastatic content of the urine is between 15 and 45 units (Wohlgemuth's method); that of the feces is about 200 units. In anacidity of the stomach the diastase of the urine and feces is moderately increased. It is probable here that Wohlgemuth's suggestion that the salivary diastase, escaping destruction in the stomach, accounts for the increase, is correct. With hyperacidity normal values are again found. Continuous hypersecretion of the stomach, whether accompanied by hyperacidity or not, is usually associated with a similar hypersecretion of pancreatic juice. In this condition the urine may contain 50 to 800 units of diastase, with simultaneous increase of fecal diastase to 2000 units and more. This shows that examination of the urine alone may lead to error, since increase of diastase occurs with gastric hypersecretion as well as with diseases of the pancreas. There is, however, this important difference: While with pancreatic disease, the amylolytic enzyme of the feces is totally lacking or present only in traces, with gastric hypersecretion fecal amylase is very greatly increased. It is evident, therefore, in the application of this diagnostic procedure that determinations of diastase should be made on both urine and feces in doubtful cases.

A New Method for the Determination of Total Nitrogen in Urine.—O. Folin and C. J. Farmer (*Jour. Biol. Chem.*, 1912, xi, 493) describe a method for determination of total nitrogen in the urine, which, in principle, is a microchemical method based on the Kjeldahl-Gunning process for decomposing nitrogenous materials and on the methods of Nessler and of Folin for the determination of ammonia. *Method:* "Five c.c. of urine are measured into a 50 c.c. measuring flask if the specific gravity of the urine is over 1.018, or into a 25 c.c. flask if the specific gravity is less than 1.018. The flask is filled to the mark with water and inverted several times to secure thorough mixing. One c.c. of the diluted urine is then measured into a large test tube made of Jena glass (size 20 to 25 mm. by 200 mm.). To the urine in the test tube add 1 c.c. of concentrated sulphuric acid, 1 gram of potassium sulphate, 1 drop of 5 per cent. copper sulphate solution, and a small, clean quartz pebble (to prevent bumping). Boil over a micro-burner for about six minutes, *i. e.*, about two minutes after the mixture has become colorless. Allow to cool about three minutes, until the digestion mixture is beginning to become viscous (it must not be allowed to solidify). Then add about 6 c.c. of water, at first a few drops at a time, then more rapidly, so as to prevent the mixture from solidifying. To the acid solution is then added an excess of sodium hydrate (3 c.c. of saturated solution) and the ammonia is aspirated by means of a rapid air current into a measuring flask (volume 1000 c.c.) containing about 20 c.c. of water and 2 c.c. of $\frac{n}{10}$ hydrochloric acid. The air current used for driving off the ammonia may well be rather moderate for the first two minutes but thereafter for eight minutes should be as rapid as the apparatus can stand. Now disconnect, dilute the contents in the flask to about 60 c.c., and dilute similarly 1 mgm. of nitrogen in the form of ammonium sulphate, to about the same volume in a second measuring flask. Nesslerize both solutions as nearly as possible at the same time with 5 c.c. of Nessler's reagent diluted immediately before hand with about 25 c.c. of water. (Five c.c. of Nessler's reagent gives the maximum color with 1 to 2 mgms. of ammonia, and when diluted as indicated, turbidity is avoided.) The color produced does not react the maximum till the